March 31, 2000

Ms. Jennifer Ryan
Health Care Financing Administration
7500 Security Boulevard
Mail Stop: S2-01-13
Baltimore, Maryland 21244

Dear Ms. Ryan:

As required by the State Children=s Health Insurance Program (SCHIP) statutory provisions, we are hereby forwarding Michigan=s combined SCHIP evaluation and fiscal year 1999 SCHIP annual report of our MIChild program.

The implementation of the SCHIP program in Michigan has resulted in almost 100% of Michigan=s children having access to health insurance. Between implementation of the program and September 1999, Michigan provided health care coverage to 68% of the eligible population. As of December 1999, Michigan provided health coverage to over 77% of the eligible population.

Michigan=s success at providing needed health care coverage has been especially apparent in the MIChild dental program. In fact, Michigan has initiated a new Medicaid dental program called Healthy Kids Dental modeled after the success the MIChild dental program has had in improving access to dental care.

A December 1999, Consumer Satisfaction Survey of MIChild families showed that the MIChild program has been very effective in providing needed health services to children. According to the survey, nearly 90% of children had seen a doctor and approximately 70% had seen a dentist. In addition, 88% of families that received services rated their doctor as AGood to Excellent@ and 81% of families rated their dentist as AGood to Excellent. "

The MIChild program will continue to grow and accomplish its purpose into the future. If you have any questions regarding our report, please contact me. Thank you for your continued and ongoing assistance with this program.

Cordially,

James K. Haveman, Jr.

Enclosure

cc: Cheryl Harris
Ruth Hughes
Faith Covici

FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: Michigan
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

Date: _____

Reporting Period: **Fiscal Years 1998 & 1999**

Contact Person/Title: **Kathleen L. Tobin, Director**
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Developed by the National Academy for State Health Policy

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

It is estimated that there were approximately 106,000 uninsured Michigan children living in families with income at or below 200 percent of the federal poverty level. This estimate is based on Michigan specific data obtained from the 1997 National Survey of American Families by the Urban Institute. This is less than the original estimate of 156,000 uninsured children which was based on information provided by HCFA, taken from the Current Population Survey (CPS, 1993-1995).

1.1.1 What are the data source(s) and methodology used to make this estimate?

See above.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The state believes the estimate from the Urban Institute is more accurate than the estimate used by HCFA because: 1) it is based on a more recent time period; 2) the Urban Institute used a sample of families three times the sample size used by the CPS; and 3) the Urban Institute's estimate more closely reflects what the State of Michigan has actually experienced during the enrollment process.

The Urban Institute and others believe that the CPS estimates used by HCFA in the initial estimates undercounted Medicaid enrollments and therefore

overestimated the number of uninsured likely eligible for SCHIP and Medicaid. It is believed that this undercount occurs when families are sampled because a significant number of Medicaid beneficiaries report that they do not have health insurance either because they do not consider Medicaid to be health insurance or because they do not want to be associated with what they perceive to be a welfare stigmatized program.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

Michigan has made significant strides at increasing the number of children with creditable health coverage. With implementation of the SCHIP program (known as MIChild/Healthy Kids expansion in Michigan), almost 100 percent of Michigan's children have access to health insurance. Since full implementation of the MIChild/Healthy Kids expansion, Michigan has enrolled approximately 27,000 children in the SCHIP program. Michigan's successful outreach program has found an additional 45,000 children who applied for the SCHIP program but who were determined Medicaid eligible. This means that over 72,000 children received health insurance coverage since implementation of the SCHIP program and September 1999. This number increases to 82,000 as of December 1999. Michigan has therefore covered 68 percent of the eligible population within one year of the program's full implementation date of September 1998 and over 77 percent within 15 months of the program's full implementation date.

CHIP (
expanded Med
FPL).

The expanded Medicaid eligible group was added due to CHIP and thus

1.2.1 What are the data source(s) and methodology used to make this estimate?

The SCHIP numbers are rounded from actual counts of enrollees in Michigan's SCHIP program. Approximately 15,000 children received coverage under the private MIChild program (see Table 4.1.1./Table B). Approximately, 12,000 children received coverage under the Healthy Kids expansion (see Table 4.1.1/Table B -- second table). The estimate of 45,000 children enrolled in Medicaid due to the MIChild/Healthy Kids outreach campaign is a conservative estimate based on 25,217 SCHIP applications that were received by the MIChild Administrative Contractor during fiscal years 1998 & 1999 and subsequently determined to be Medicaid eligible. The total number of children referred to the Medicaid program due to the MIChild/Healthy Kids outreach

campaign can be found by multiplying the number of applications determined to be Medicaid eligible by the Administrative Contractor times the average number of children per application (25,217 X 1.8 = 45,390).

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Michigan's count of MIChild/Healthy Kids enrollees is an actual count based on the number of children enrolled. With respect to Michigan's estimate of the increase in the number Medicaid eligibles found due to the MIChild/Healthy Kids outreach campaign, it is a conservative estimate. This is because an unknown number of SCHIP-generated Medicaid applications entered the eligibility determination process at the local level, and thereby are not included in the 25,217 counted by the Administrative Contractor.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
1. To increase the number of low-income children in Michigan with creditable health insurance coverage by means of moving the estimated 156,000 children under age 19 without health insurance into either accessible, quality Medicaid or MIChild coverage while not simultaneously "crowding out" private coverage.	**Goal 1: Enroll the estimated 156,000 uninsured, low-income children in Michigan in either the Medicaid program or the MIChild program, as appropriate**.	**Data Sources: For numerator, MIChild enrollment file and count of MIChild/Healthy Kids (Medicaid) common applications processed; for denominator, Urban Institute's 1997 National Survey of American Families.** **Methodology: Count number of MIChild applicants enrolled through 9/99; count estimated number of Healthy Kids (Medicaid) enrollees based on number of applications found likely to represent Medicaid eligibles at initial eligibility screening x 1.8 children per application.** **Numerator: 14,825 MIChild (private insurance model) + 11,827 (expand Medicaid eligibility) + 45,390 (other Medicaid enrolled children) = 72,042** **Denominator: 106,000 children under age 19 whose family income is at or below 200 percent of FPL.** **Progress Summary: 72,042/106,000 = 68%**

OBJECTIVES RELATED TO CHIP ENROLLMENT		
	Goal 2: Enroll in the MIChild program 100 percent of eligible children who participate in the Caring Program for Children.	**Data Sources: Blue Cross and Blue Shield of Michigan file of Caring Program for Children enrollees, October 1998. MIChild enrollment file as maintained by the state's Administrative Contractor.** **Methodology: Count number of Caring Program children into MIChild as of October 1998 (2,945) .** **Numerator: 2,945 as of 10/98** **Denominator: 2,945** **Progress Summary: 100 percent of Caring Program for Children were enrolled into MIChild as of October 1998.**

	Goal 3: Obtain accurate, usable HEDIS reports from MIChild providers and monitor the following outcomes with emphasis on: **a. well-child examinations** **b. immunizations** **c. receipt of at least one (1) physician visit per MIChild enrollee annually** **d. receipt of at least one (1) dental examination per MIChild enrollee annually.**	**Data Sources: HEDIS reports from plans.** **Methodology: Standard HEDIS methodology.** **Numerator: Service monitored** **Denominator: Population sampled** **Progress Summary: HEDIS data is considered valid and reliable when obtained from a period of twelve consecutive months of managed care enrollment for the enrollee studied. Since MIChild was not fully operational until calendar year 1999, we plan to have accurate and usable HEDIS reports by approximately June 2000. This time schedule was not anticipated when program goals were formulated. As a partial substitute, the state developed and administered, through its Administrative Contractor, a client satisfaction survey designed to elicit some measure of feedback as to how the program is performing. Details on the survey are provided in Attachment I of this report.**
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		

	Goal 4: Local agencies and programs will contact low-income families representing 156,000 uninsured children and make known to the families the availability of Medicaid and MIChild health insurance coverage.	**Data Sources**: **Reports of local agencies under contract to the Department during CY 1999.** **Methodology**: **Total counts of outreach contacts made by contracted agencies.** Numerator: **Contacts made.** Denominator: **Contacts possible.** Progress Report: **Contracted agency reports did not disclose the number of contacts made. The extent of these agencies' efforts was far-reaching and suggests the goal was likely substantially met.**
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
	Goal 5: Provide an application and enrollment process that is easy for families to understand and use.	Data Sources: **Informal Family Satisfaction Survey** Methodology: **Random sample of MIChild families asked whether the enrollment & eligibility determination process was easy. In addition, a draft application was tested and revised based on discussions with focus groups.** Numerator: **Number giving favorable response** Denominator: **Number sampled** Progress Summary: **73% said process was good-excellent;** **91% said process was average, good, or excellent.** **(See Attachment 1, Question 3.)**

OTHER OBJECTIVES		
	Goal 6: Obtain the participation of community-based organizations in outreach and education activities.	Data Sources: **Contracts with Multi-Service Collaborative Bodies** Methodology: **Multi-Service Collaborative Bodies are local organizations composed of human service agencies, schools, courts, welfare agencies, health departments, community mental health, etc. that join to work together on projects of human service interest.** **The research question is, "Did the state contract with all Multi-Service Collaborative Bodies relative to MIChild outreach?"** Numerator: **Number of Multi-Service Collaborative Bodies contracted for MIChild outreach** Denominator: **Number of Multi-Service Collaborative Bodies existing in state.** Progress Summary: **100 percent of Multi-Service Collaborative Bodies were under contract for MIChild outreach activities.**

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

__**x**_ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: **Healthy Kids, 16-18 years old**

Date enrollment began (i.e., when children first became eligible to receive services): **April 1998**

_**x**__ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: **MIChild**

Date enrollment began (i.e., when children first became eligible to receive services): **May 1998**

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 If State offers family coverage**:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.1.3 If State has a buy-in program for employer-sponsored insurance: Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Michigan held public forums throughout the state in order to find out what providers and beneficiaries thought should be included in a new health program for children. Overwhelmingly, participants wanted a state designed program that looked like a private health insurance program and did <u>not</u> want a Medicaid expansion. The idea of requiring a premium and copays was widely accepted.

We also used our experience with our Medicaid dental program to develop a a preventive focused service package with commensurate pricing that proved attractive to providers. As a result, we have excellent MIChild dental access, children are receiving needed dental care, and providers are willing to accept MIChild patients.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

___ No pre-existing programs were "State-only"

_X_ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

As referenced previously, Michigan had a Caring Program for Children in existence with approximately 3,000 children. The Caring Program was discontinued October 1998, after the state successfully transferred 100% of the children to MIChild. The Caring Program did not figure in design of MIChild, but we wanted to retain the health coverage these children were receiving as we transitioned into SCHIP, especially since the Caring Program population was generally the same target population as SCHIP.

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

___ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
_ _ Provision of continuous coverage (specify number of months ___)
___ Elimination of assets tests
__ Elimination of face-to-face eligibility interviews
_X_ Easing of documentation requirements

Other: Joint, easy application for MIChild/Healthy Kids
No wrong door policy allows State to accept applications wherever received. Central processing of Healthy Kids applications-used for limited time period.

___ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)_____

__X__ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- __X__ Health insurance premium rate increases
- ___ Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- __X__ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____

As of late fiscal year 1999, health care insurers were significantly raising premiums, co-payments, and deductibles. It appears this is more pronounced with lower-paid workers. Worker response is not determined, especially whether workers will opt to retain the higher costing, employer-based coverage or will drop the coverage and wait six months, with their children being uninsured, in order to qualify for MIChild. (State anti-crowd out MIChild policy specifies a six-month waiting/penalty period without child health insurance coverage if the worker drops employer-based coverage.)

___ Changes in the delivery system

- ___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- ___ Changes in hospital marketplace (e.g., closure, conversion, merger)
- ___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify) _____

___ Changes in the demographic or socioeconomic context

- ___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____
- ___ Changes in economic circumstances, such as unemployment rate (specify) _____
- ___ Other (specify)_____

___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	**Statewide**	**Statewide**	**NA**
Age	**16, 17, & 18 year olds**	**0-18 (Up to age 19)**	**NA**
Income (define countable income)	**Up to 150% of FPL**	**151-200% of FPL, except infants 186-200% of FPL**	**NA**
Resources (including any standards relating to spend downs and disposition of resources)	**No asset test**	**No asset test**	**NA**
Residency requirements	**State Resident or migrant worker family**	**State Resident or migrant worker family**	**NA**
Disability status	**NA**	**NA**	**NA**
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	**ok, other coverage billed first**	**Coverage of employer-provided health insurance disqualifies**	**NA**
Other standards (identify and describe)	**Must be eligible to receive benefits based on federal citizenship law**	**Must be eligible to receive benefits based on federal citizenship law**	**NA**

- Countable income = most earned and unearned income minus allowable deductions.

**Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* __**NA**_____
Monthly			
Every six months			
Every twelve months	**X**	**X**	
Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

__**X**_ Yes ° Which program(s)?
SCHIP/MIChild

For how long?
12 Months

___ No

3.1.4 Does the CHIP program provide retroactive eligibility?

_**X**__ Yes ° Which program(s)?
Medicaid expansion.

How many months look-back?
Three months previous to month of application

__ No

3.1.5 Does the CHIP program have presumptive eligibility?

_**X**__ Yes ° Which program(s)? **MIChild plans have the option to provide presumptive elgibility but none have taken the option.**

Which populations?

Who determines?

___ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

__**X**_ Yes ° Is the joint application used to determine eligibility for other State programs? If yes, specify.

Joint application determines eligibility for MIChild, Healthy Kids/Medicaid, and pregnant women at or below 185% of FPL.

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Strengths

- **The joint MIChild/Healthy Kids application makes application easier for families. The application is a two-page, two-sided form and is presented in an easy to understand format. Families do not have to determine whether MIChild or Healthy Kids is the appropriate program for them and accordingly do not have to apply separately for each program. The state does the determination.**
- **The state has adopted a "No Wrong Door" policy, meaning, applications for the programs will be accepted by a variety of places including: Maximus (the administrative contractor), local TANF offices, or local health departments. The joint application can be mailed rather than requiring the family to appear in person for a face-to-face determination at the local TANF office.**

Weaknesses

Some families that apply for MIChild yet are determined eligible for Medicaid are very upset that they must enroll in the Medicaid program in order to receive health benefits for their children. Over 700 families have requested enrollment into the MIChild program but were not allowed to do so due to the federal law which does not allow Medicaid eligibles to enroll in a state based program.

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Strengths

In order to make it as easy as possible for families to reapply at redetermination, a preprinted form that summarizes the families' eligibility information is mailed to them. Families are then asked to confirm the

information and reverify income. We provide sufficient lead time for the family to complete and mail the redetermination application. If the family does not meet the due date, we provide an additional 30 day grace period. During this grace period, further attempts are made to contact the family.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 3.2.1 CHIP Program Type Separate MIChild			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	**X**	**No**	**No, other than medical necessity**
Emergency hospital services	**X**	**No**	**No, other than medical necessity**
Outpatient hospital services	**X**	**No**	**No, other than medical necessity**
Physician services	**X**	**No**	**No, other than medical necessity**
Clinic services	**X**	**No**	**No, other than medical necessity**
Prescription drugs	**X**	**No**	**No, other than medical necessity**
Over-the-counter medications	**No**	**N/A**	
Outpatient laboratory and radiology services	**X**	**No**	**No, other than medical necessity**
Prenatal care	**X**	**No**	**No, other than medical necessity**
Family planning services	**X**	**No**	**No, other than medical necessity**
Inpatient mental health services	**X**	**No**	**No, other than medical necessity**
Outpatient mental health services	**X**	**No**	**No, other than medical necessity**
Inpatient substance abuse treatment services	**X**	**No**	**No, other than medical necessity**
Residential substance abuse treatment services	**X**	**No**	**No, other than medical necessity**
Outpatient substance abuse treatment services	**X**	**No**	**No, other than medical necessity**
Durable medical equipment	**X**	**No**	**No, other than medical necessity**
Disposable medical supplies	**X**	**No**	**No, other than medical necessity**
Preventive dental services	**X**	**No**	**$600 per child annual limit (allowed 2 visits per year)**
Restorative dental services	**X**	**No**	**$600 per child annual limit**
Hearing screening	**X**	**No**	**No, other than medical necessity**
Hearing aids	**X**	**No**	**No, other than medical necessity**
Vision screening	**X**	**No**	**No, other than medical necessity**
Corrective lenses (including eyeglasses)	**X**	**No**	**Once per 24 months, or once per 12 months if a change in prescription is needed.**
Developmental assessment	**X**	**No**	**No, other than medical necessity**
Immunizations	**X**	**No**	**No, other than medical necessity**

Well-baby visits	**X**	**No**	**No, other than medical necessity**
Well-child visits	**X**	**No**	**No, other than medical necessity**
Physical therapy	**X**	**No**	**No, other than medical necessity**
Speech therapy	**X**	**No**	**No, other than medical necessity**
Occupational therapy	**X**	**No**	**No, other than medical necessity**
Physical rehabilitation services	**No**	**N/A**	
Podiatric services	**X**	**No**	**No, other than medical necessity**
Chiropractic services	**X**	**No**	**No, other than medical necessity**
Medical transportation	**X**	**No**	**For medical emergencies only**
Home health services	**X**	**No**	**No, other than medical necessity**
Nursing facility	**X**	**No**	**Skilled NF, up to 120 days**
ICF/MR	**X**	**No**	**Authorized through community mental health if deemed necessary.**
Hospice care	**X**	**No**	**Up to 210 days – two periods of 90 days each, and one period of 30 days.**
Private duty nursing	**X**	**No**	**No, other than medical necessity**
Personal care services	**No**	**N/A**	
Habilitative services	**No**	**N/A**	
Case management/Care coordination	**X**	**No**	**No, other than medical necessity**
Non-emergency transportation	**No**	**N/A**	
Interpreter services	**X**	**No**	**As needed**
Other (Specify) **Acupuncture**	**X**	**No**	**When performed by physician, up to 20 visits annually for specified illnesses**
Other (Specify) **Organ & Tissue Transplants**	**X**	**No**	**Experimental and artificial organs excluded**
Other (Specify) **Prosthetic & Orthotic Appliances**	**X**	**No**	**No, other than medical necessity**

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 3.2.1 CHIP Program Type Medicaid MIChild			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	**X**	**No**	**No, other than medical necessity**
Emergency hospital services	**X**	**No**	**No, other than medical necessity**
Outpatient hospital services	**X**	**No**	**No, other than medical necessity**
Physician services	**X**	**No**	**No, other than medical necessity**
Clinic services	**X**	**No**	**No, other than medical necessity**
Prescription drugs	**X**	**No**	**No, other than medical necessity**
Over-the-counter medications i.e., aspirin, antacids	**X**	**No**	**No, other than medical necessity**
Outpatient laboratory and radiology services	**X**	**No**	**No, other than medical necessity**
Prenatal care	**X**	**No**	**No, other than medical necessity**
Family planning services	**X**	**No**	**No, other than medical necessity**
Inpatient mental health services	**X**	**No**	**No, other than medical necessity**
Outpatient mental health services	**X**	**No**	**No, other than medical necessity**
Inpatient substance abuse treatment services	**X**	**No**	**No, other than medical necessity**
Residential substance abuse treatment services	**X**	**No**	**No, other than medical necessity**
Outpatient substance abuse treatment services	**X**	**No**	**No, other than medical necessity**
Durable medical equipment	**X**	**No**	**No, other than medical necessity**
Disposable medical supplies	**X**	**No**	**No, other than medical necessity**
Preventive dental services	**X**	**No**	**No, other than medical necessity**
Restorative dental services	**X**	**No**	**No, other than medical necessity**
Hearing screening	**X**	**No**	**No, other than medical necessity**
Hearing aids	**X**	**No**	**No, other than medical necessity**
Vision screening	**X**	**No**	**No, other than medical necessity**
Corrective lenses (including eyeglasses)	**X**	**No**	**No, other than medical necessity**
Developmental assessment	**X**	**No**	**No, other than medical necessity**
Immunizations	**X**	**No**	**No, other than medical necessity**
Well-baby visits	**X**	**No**	**No, other than medical necessity**

Well-child visits	**X**	**No**	**No, other than medical necessity**
Physical therapy	**X**	**No**	**No, other than medical necessity**
Speech therapy	**X**	**No**	**No, other than medical necessity**
Occupational therapy	**X**	**No**	**No, other than medical necessity**
Physical rehabilitation services	**X**	**No**	**Included in above noted services.**
Podiatric services	**X**	**No**	**No, other than medical necessity**
Chiropractic services	**X**	**No**	**No, other than medical necessity**
Medical transportation	**X**	**No**	**No, other than medical necessity**
Home health services	**X**	**No**	**No, other than medical necessity**
Nursing facility	**X**	**No**	**No, other than medical necessity**
ICF/MR	**X**	**No**	**Authorized through community mental health if deemed necessary.**
Hospice care	**X**	**No**	**No, other than medical necessity**
Private duty nursing	**X**	**No**	**No, other than medical necessity**
Personal care services (Home Help)	**X**	**No**	**No, other than medical necessity**
Habilitative services	**No**	**N/A**	
Case management/Care coordination	**X**	**No**	**No, other than medical necessity**
Non-emergency transportation	**X**	**No**	**No, other than medical necessity**
Interpreter services	**X**	**No**	**As needed**
Other (Specify) **Organ & Tissue Transplants**	**X**	**No**	**Experimental and artificial organs excluded**
Other (Specify) **Prosthetic & Orthotic Appliances**	**X**	**No**	**No, other than medical necessity**

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose “select” “table.” Once the table is highlighted, copy it by selecting “copy” in the Edit menu and then “paste” it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

MIChild offers a comprehensive range of services, including preventative and specialty care services for children with special health care needs at nominal cost to the family. MIChild covers all medically necessary services.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3

Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	**X** Yes ___ No	**X** Yes ___ No	___ Yes ___ No
Mandatory enrollment?	**X** Yes ___ No	**X** Yes ___ No	___ Yes ___ No
Number of MCOs	**27**	**13 medical**	
B. Primary care case management (PCCM) program			
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	**Community mental health programs & substance abuse coordinating agencies**	**Community mental health programs, substance abuse coordinating agencies, and four dental plans**	
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	**Dental**		

E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4

__X_ Yes, check all that apply in Table 3.3.1

Table 3.3.1			
Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____
Premiums	**No**	**$5 per family per month**	
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

The MIChild premium is $5 per family per month. It may be paid monthly, annually, etc. There is no variance of amount by income, family size, or other criteria. If the family fails to pay the premium, the family must wait until the next open enrollment period to reapply for coverage. Open enrollment periods are January and September in the year 2000.

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

_X__ Employer **(assuming family does not have employer-based coverage)**
_X_ Family
_X__ Absent parent
_X_ Private donations/sponsorship
_X__ Other (specify) **_Any other source--no disqualification based on source**

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

N/A

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

N/A

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

By letter, at enrollment into program & at redetermination of eligibility.

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
__X_ Other (specify) __**Annual, aggregate cost sharing is $60. It is not**

possible for a family to be MIChild eligible and to exceed the 5 percent income threshold.

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

None

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

Before the program was implemented, the state held public forums throughout the state. During those forums, most people supported the payment of premiums as they interpreted it closer to a private health insurance model.

An April 1999 survey of 1400 families who were paying premiums late disclosed that the majority said they just forgot to send the money.

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards	**X**	**4**	**X**	**4**		
Brochures/flyers	**X**	**4-5**	**X**	**4-5**		
Direct mail by State/enrollment broker/administrative contractor	**X**	**2-3**	**X**	**2-3**		
Education session-info sessions & presentations	**X**	**3**	**X**	**3-4**		
Home visits by State/enrollment broker/administrative contractor	**X**	**2**	**X**	**2**		
Hotline	**X**	**4**	**X**	**4**		
Incentives for education/outreach staff						
Incentives for enrollees	**X**	**5**	**X**	**5**		
Incentives for insurance agents						
Non-traditional hours for application intake	**X**	**Ratings Varied**	**X**	**Ratings Varied**		
Prime-time TV advertisements	**X**	**5**	**X**	**5**		
Public access cable TV	**X**	**4**	**X**	**4**		
Public transportation ads-bus signs	**X**	**2-3**	**X**	**2-3**		
Radio/newspaper/TV advertisement and PSAs	**X**	**5**	**X**	**5**		
Signs/posters	**X**	**3-4**	**X**	**4**		
State/broker initiated phone calls	**X**	**1**	**X**	**1**		
Other (specify) Special mailing and recruitment of spend-down cases			**X**	**2**		
Other (specify)Special mailing and recruitment of families originally denied for being over income (state changed income calculation methodology)			**X**	**4**		
Special mailings and recruitment of Caring Program for Children families			**X**	**4**		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a

table, right click on the mouse, select “insert” and choose “column”.

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters	**X**	**3**	**X**	**3**		
Community sponsored events	**X**	**4-5**	**X**	**4-5**		
Beneficiary's home	**X**	**4-5**	**X**	**4-5**		
Day care centers	**X**	**5**	**X**	**5**		
Faith communities	**X**	**5**	**X**	**5**		
Fast food restaurants	**X**	**3-4**	**X**	**3-4**		
Grocery stores	**X**	**3-4**	**X**	**3-4**		
Homeless shelters	**X**	**3-4**	**X**	**3-4**		
Job training centers	**X**	**4**	**X**	**4**		
Laundromats	**X**	**3**	**X**	**3**		
Libraries	**X**	**3**	**X**	**3**		
Local/community health centers	**X**	**5**	**X**	**5**		
Point of service/provider locations	**X**	**5**	**X**	**5**		
Public meetings/health fairs	**X**	**4-5**	**X**	**4-5**		
Public housing	**X**	**3**	**X**	**3**		
Refugee resettlement programs	**X**	**4**	**X**	**4**		
Schools/adult education sites	**X**	**5**	**X**	**5**		
Senior centers	**X**	**2-3**	**X**	**2-3**		
Social service agency	**X**	**5**	**X**	**5**		
Workplace	**X**	**4-5**	**X**	**4-5**		
Other (specify)State & County Fairs	**X**	**5**	**X**	**5**		

Other (specify) Community Colleges Doctors' Offices Small Businesses: hair salons, used car lots strip clubs, pawn shops, casinos, thrift shops	**X** **X** **X**	**2** **4** **3**	**X** **X** **X**	**2** **4** **3**		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target a population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

When prospective applicants telephone the Administrator Contractor, they are asked how they learned about the program. This information is recorded, totaled, and reported monthly. From this process, we have learned that families most frequently learn about MIChild/Healthy Kids from the media and schools.

The Administrative Contractor keeps track of the type of agency requesting written MIChild materials. Schools were the most frequent requesters and asked for materials twice as often as the number two requester-community agencies. A close third was health centers.

The Administrative Contractor records each week the total number of MIChild calls received, number of applications requested and received, and number of applications resulting in MIChild enrollments vs. number of applications received that represent Medicaid eligibles. These are monitored for weekly and monthly changes.

Table 3.4.1 documents the Administrative Contractor's and State personnel's judgment of the effectiveness of special, outreach mailings.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

Translated materials-Arabic & Spanish

Outreach workers of same ethnic group, faith-based organizations involved, and peer programs.

In the respective communities, locally owned newspapers, radio stations, and cable television were widely used. Outreach workers were physically located, Monday through Friday, at local Family Independence Agency offices for assistance with language and cultural barriers.

State Administrative Contractor has bilingual staff (Russian, Arabic, & Spanish) at telephone call center as well as access to AT&T language line.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

Television ads, Public Service Announcements, and brochure/application dissemination through the schools were by far the most effective. This statement is based on telephone calls to the state Administrative Contractor who asks where the callers learned about the program.

For targeted populations, the best approaches were the use of their own radio and television programs, newspapers, and home visits to the non-English speaking populations.

Table 3.4.1 includes ratings of the most successful outreach approaches.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5				
Type of coordination	Medicaid*	Maternal and child health	Other (specify) **WIC_____**	Other (specify) **_School Lunch**
Administration	**X**			
Outreach	**X**	**X**	**X**	**X**
Eligibility determination	**X**			
Service delivery				
Procurement	**X**			
Contracting	**X**			
Data collection				
Quality assurance	**X**			
Other (specify)				
Other (specify)				

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

Nature of Coordination

Administration/Medicaid: **Same state management-CHIP & Medicaid.**
Outreach/Medicaid: **Joint outreach effort both programs.**
Outreach/MCH: **MCH management promoted CHIP/MIChild.**
Outreach/WIC: **Targeted mailing to WIC non-Medicaid recipients.**
Outreach/School Lunch: **9/98, all children received application if enrolled in school with over 50% of school lunch use. Brochures and applications sent to all schools.**
Eligibility Determination: **Same state staff and management for SCHIP and Medicaid.**
Procurement: **Same procurement process for administrative contractor.**
Contracting: **Same Admin. Contractor for both SCHIP and Medicaid.**
Quality Assurance: **Same state staff do SCHIP and Medicaid Quality Assurance.**

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

X Eligibility determination process:

X Waiting period without health insurance. **Six month waiting period if the family drops employer-based health insurance coverage.**

_X_ Information on current or previous health insurance gathered on application **Applicants asked about other health insurance coverage at time of (re)application. Information provided is factor in determining eligibility.**

___ Information verified with employer (specify)

___ Records match (specify)

_X_ Other **We established policy and procedures whereby plans may report incidents to Administrative Contractor if beneficiary is determined to have other comprehensive coverage with plan. Children are dropped from MIChild if other comprehensive coverage was present at time of application and family misrepresented.**

___ Other (specify)

___ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing (specify)
___ Other (specify)
___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

We investigate instances of beneficiaries who are thought to have other insurance at time of application and family failed to disclose. Through fiscal year 1999, approximately 20 cases were brought to our attention by the plans. Most of these were resolved such as by determining that the dual coverage occurred after MIChild enrollment, which is permissible per our policy. A few families did ask for disenrollment, perhaps suggesting a problem with the original application. Overall, we have found few cases of apparent misrepresentation by families; crowd-out does not appear to us to be occurring or to otherwise be a problem.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 4.1.1 CHIP Program Type **_MIChild_____** ***(Table B)***

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Percentage of Unduplicated Enrollees Per Year	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	**182**	**14,825**	**1.7**	**6.6**	**97.8%**	**77.9%**
Age						
Under 1	**2**	**108**	**1.5**	**3.6**	**100%**	**50.9%**
1-5	**44**	**4,411**	**1.7**	**5.7**	**100%**	**79.2%**
6-12	**94**	**6,130**	**1.7**	**6.7**	**97.9%**	**83.1%**
13-18	**42**	**4,176**	**1.6**	**7.5**	**95.2%**	**69.7%**

Countable Income Level*						
At or below 150% FPL						
Above 150% FPL	**182**	**14,825**	**1.7**	**6.6**	**97.8%**	**77.9%**
Age and Income						
Under 1						
At or below 150% FPL						
Above 150% FPL	**2**	**108**	**1.5**	**3.6**	**100%**	**50.9%**
1-5						
At or below 150% FPL						
Above 150% FPL	**44**	**4,411**	**1.7**	**5.7**	**100%**	**79.2%**
6-12						
At or below 150% FPL						
Above 150% FPL	**94**	**6,130**	**1.7**	**6.7**	**97.9%**	**83.1%**
13-18						
At or below 150% FPL						
Above 150% FPL	**42**	**4,176**	**1.6**	**7.5**	**95.2%**	**69.7%**
Type of plan						
Fee-for-service						
Managed care	**182**	**14,825**	**1.7**	**6.6**	**97.8%**	**77.9%**
PCCM						

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

Table 4.1.1 CHIP Program Type **_Healthy Kids (Expanded Eligibility)_ (Table B)_____**

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Percentage of Unduplicated Enrollees Per Year	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	**6,044**	**11,827**	**3.2**	**6.4**	**63%**	**53.6%**
Age						
Under 1						
1-5						
6-12						
13-18	**6,044**	**11,827**	**3.2**	**6.4**	**63%**	**53.6%**
Countable Income Level*						
At or below 150% FPL	**6,044**	**11,827**	**3.2**	**6.4**	**63%**	**53.6%**
Above 150% FPL						
Age and Income						
Under 1						
At or below 150% FPL						
Above 150% FPL						
1-5						
At or below 150% FPL						
Above 150% FPL						
6-12						
At or below 150% FPL						
Above 150% FPL						

13-18						
At or below 150% FPL	**6,044**	**11,827**	**3.2**	**6.4**	**63%**	**53.6%**
Above 150% FPL						
Type of plan						
Fee-for-service	**1,962**	**3,426**	**2.9**	**5.5**	**50.2%**	**44.7%**
Managed care	**2,208**	**5,923**	**3.3**	**6.3**	**75%**	**59%**
PCCM	**1,874**	**2,478**	**3.6**	**7.7**	**62.3%**	**52.9%**

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

Approximately 3,000 children were enrolled in the Caring Program for Children prior to SCHIP's implementation. No other data are available.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

3,600 disenrollments from MIChild through the end of fiscal year 1999.

Based on initial, annual redeterminations of eligibility, we found a higher than expected loss of enrollees at the time of redeterminations mainly due to obtaining private coverage or becoming eligible for Medicaid. During a recent survey of families that did not continue enrollment in the MIChild program, approximately 90 percent of children who left the program were receiving health coverage through an alternative source (private or Medicaid).

MIChild/SCHIP disenrollments are lower than Medicaid disenrollment rates because MIChild enrollees are guaranteed 12 months of continuous enrollment once determined program eligible.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP? **See above**

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.) **In a recent survey of families who left the MIChild program, 86% were receiving some form of other insurance, 4% forgot to mail the application and 10% cited other reasons.**

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total						
Access to commercial insurance						
Eligible for Medicaid			**1,026**			
Income too high			**20**			
Aged out of program			**507**			
Moved/died						
Nonpayment of premium			**953**			
Incomplete documentation			**24**			
Did not reply/unable to contact			**1,054**			
Other (specify)						
Other (specify)						
Don't know						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

At all redeterminations, families are encourage via mail and phone to re-enroll in the program. The state also engages in an extensive outreach campaign through the media, schools, and physicians' offices to encourage families to apply for the program.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 **$2.7 Million**

FFY 1999 **$25.40 Million**

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type **MIChild**

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	**$30,924**	**$7.48 Million**	**Not billed to HCFA.**	**$5.01 Million**
Premiums for private health insurance (net of cost-sharing offsets)*	**$30,924**	**$7.48 Million**	**Not billed to HCFA.**	**$5.01 Million**
Fee-for-service expenditures (subtotal)	**$0**	**$0**	**$0**	**$0**
Inpatient hospital services				
Inpatient mental health facility services				

Nursing care services				
Physician and surgical services				
Outpatient hospital services				
Outpatient mental health facility services				
Prescribed drugs				
Dental services				
Vision services				
Other practitioners' services				
Clinic services				
Therapy and rehabilitation services				
Laboratory and radiological services				
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services				
Home health				
Home and community-based services				
Hospice				
Medical transportation				
Case management				
Other services				

Table 4.3.1 CHIP Program Type __**Healthy Kids/Medicaid**				
Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	**$0.97 Million**	**$12.58 Million**	**$0.67 Million**	**$8.42 Million**
Premiums for private health insurance (net of cost-sharing offsets)*	**$0.27 Million**	**$6.39 Million**	**$0.19 Million**	**$4.27 Million**
Fee-for-service expenditures (subtotal)		**$6.19 Million**		**$4.15 Million**
Inpatient hospital services	**$0.18 Million**	**$2.30 Million**	**$0.12 Million**	**$1.54 Million**
Inpatient mental health facility services	**$0**	**$0**		**$0**
Nursing care services	**$0**	**$0**		**$0**
Physician and surgical services	**$0.12 Million**	**$0.96 Million**	**$0.08 Million**	**$0.64 Million**
Outpatient hospital services	**$0.10 Million**	**$0.59 Million**	**$0.07 Million**	**$0.40 Million**
Outpatient mental health facility services	**$0.10 Million**	**$0.12 Million**	**$0.07 Million**	**$0.08 Million**
Prescribed drugs	**$0.12 Million**	**$0.61 Million**	**$0.08 Million**	**$0.41 Million**
Dental services	**$0.02 Million**	**$0.56 Million**	**$.02 Million**	**$0.37 Million**
Vision services	**$.01 Million**	**$0.04 Million**	**$0**	**$0.03 Million**
Other practitioners' services		**$0.01 Million**		**$0.006 Million**
Clinic services	**$.06 Million**	**$0.75 Million**	**$.04 Million**	**$0.50 Million**
Therapy and rehabilitation services		**$0.01 Million**		**$0.01 Million**
Laboratory and radiological services		**$0.03 Million**		**$0.02 Million**
Durable and disposable medical equipment		**$0.04 Million**		**$0.03 Million**
Family planning		**$0**		**$0**
Abortions		**$0**		**$0**
Screening services		**$0**		**$0**
Home health		**$0.05 Million**		**$0.03 Million**

Home and community-based services		**$0**		**$0**
Hospice		**$0**		**$0**
Medical transportation		**$0.05 Million**		**$0.04 Million**
Case management		**$0**		**$0**
Other services		**$.07 Million**		**$.04 Million**

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Outreach and Program Administration

What role did the 10 percent cap have in program design?

State only funds were used for Outreach

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share	**Not**	**Not**	**$1.7 Million**	**$5.34 Million**		
Outreach	**Identified**	**Identified**	**$0.5 Million**	**$2.24 Million**		
Administration	**Separately**	**Separately**	**$1.2 Million**	**$3.10 Million**		
Other_____	**Included**	**Included**				
Federal share	**With**	**With**	**Not**	**$2.23 Million**		
Outreach	**State-**	**State-**	**Billed**	**$2.23 Million**		
Administration	**Designed**	**Designed**	**to**	**$0**		
Other _____	**SChip Prgm**	**SChip Prgm**	**HCFA**			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

_**X**__ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Appointment audits			
PCP/enrollee ratios	**X**		
Time/distance standards	**X**		
Urgent/routine care access standards			
Network capacity reviews (rural providers, safety net providers, specialty mix)	**X**		
Complaint/grievance/ disenrollment reviews	**X**	**X**	
Case file reviews			
Beneficiary surveys	**X**	**X**	
Utilization analysis (emergency room use, preventive care use)	**X**	**X**	
Other (specify) Provider Network Standards thru Licensure_____	**X**	**X**	
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	__**X**_ Yes ___ No	_**X**__ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	__**X**_ Yes ___ No	_**X**_ Yes ___ No	___ Yes ___ No
Other (specify) **Informal Family Survey**_____	___ Yes ___ No	__**X**_ Yes ___ No	___ Yes ___ No

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Please refer to Attachment I for results of our Consumer Satisfaction Survey.

Also, one of our dental plans, Delta Dental of Michigan, generated data on its enrollees showing the extent, and type, of services received by beneficiaries. The data summaries are presented in Attachment II. This data shows that over 45% of the services received were preventive and over 40% were restorative.

Encounter and HEDIS-based information are not yet available.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

Encounter and HEDIS will be done. Data available summer 2000 at the earliest.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
Focused studies (specify)	**X, variable as determined**		
Client satisfaction surveys	**CAHPS/HEDIS**	**CAHPS/HEDIS**	
Complaint/grievance/ disenrollment reviews	**X**	**X**	
Sentinel event reviews			
Plan site visits	**X**		
Case file reviews	**X**		
Independent peer review	**X**	**X**	
HEDIS performance measurement	**X**	**X**	
Other performance measurement (specify) **Consumer Satisfaction Survey**		**X**	
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Encounter and HEDIS data are expected to be available summer 2000. Please refer to Attachment I for results of our Consumer Satisfaction Survey.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

As identified at Table 4.5.1. Quality of care data are expected to be available summer 2000.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

In December 1999, the Administrative Contractor for the program conducted a Consumer Satisfaction Survey of MIChild families. The survey's summary and results are included as Attachment I to this report. The findings are very positive for the program. Results disclose that MIChild families are experiencing good access to services and that families are generally pleased with the program. For example, nearly 90 percent of children had seen a doctor and approximately 2/3 of children had seen a dentist. 88% of families that received these services rated their doctor as "Good to Excellent" and 81% of families rated their dentist as "Good to Excellent." Most importantly, 89% of families rates their child's health as "Good to Excellent." We will continue conducting this type of review in the future.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

1. **Developing and implementing a common application for MIChild/Healthy Kids was the appropriate approach to take since it made the eligibility (re)determination process ultimately easier for families. However, some families that wanted to be enrolled in the MIChild program were unhappy when found eligible for Healthy Kids.**

2. **The processes to determine eligibility and enrollment need to be continually evaluated and modified based on experience. The Administrative Contractor initiated three iterations of these processes during the program's first two years. Each modification further improved and streamlined the processes. Evaluation and monitoring included compliance with the state standard of ten days to process a completed MIChild application.**

3. **It is best to have an automated, operational system in place at the time of implementation rather than build the system in the program's early days.**

4. **Have clearly defined income standards in place at the time of implementation that do not change appreciably during the program's early history. The more verifications required, the more time consuming it is to process the case.**

5. **An ongoing disappointment, despite repeated attempts to address, has been the high percentage of incomplete applications received initially. This obviously results in a more lengthy processing time.**

6. Plan enrollment has gone smoothly. Most families select plans as part of their application. Having well-known plans in the programs helps with family selection because families can readily identify plans.

7. Joint state and Administrative Contractor Quality Assurance efforts on eligibility processing (the Administrative Contractor does eligibility determination work) have been successful in producing a common understanding of how to process applications. This QA process has been very useful.

5.1.2 Outreach

1. We learned that television and radio, followed by schools, were the best media for spreading the word about MIChild/Healthy Kids availability. Other efforts appear to have a negligible impact.

5.1.3 Benefit Structure

We believe we made the correct choice in designing a concentrated, kids-centered dental benefits package that emphasizes preventive and primary care rather than the "something for everyone" approach that creates a "mile-wide, inch deep" program that cannot be properly financed. The dental community has well received the MIChild dental offering. We have better access to dental care under the MIChild program than we have under our fee-for-service Medicaid dental program.

Due to the success with the MIChild program, that state is implementing a 22 county Medicaid demonstration program based on the MIChild dental program.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

1. We believe we chose correctly in making the MIChild premium affordable for families and in not encumbering benefits with copayments and deductibles so as to avoid erecting barriers to access for the children involved.

2. Premium collections efforts have been successful for most. Check and coupon options are sufficient for sending payments. We saw greater success in collecting premiums when coupons were sent with approval letters rather than when they were not (as was the case early in the program). We improved response by sending a schedule of payments along with the eligibility approval letter. A significant number of families make one payment for an entire year; however, a significant number of families

are delinquent each month in sending their monthly payments.

5.1.5 Delivery System

We believe we made the right choice when deciding the service delivery system would be a capitated, managed care service delivery model using licensed insurance/dental plans and health maintenance organizations. We have access to quality care under MIChild to state-regulated and monitored plans.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

1. We believe that designing MIChild based on a private insurance plan model was preferable to simply adding SCHIP to our Medicaid Program. This structure facilitated communication with private insurers and allowed us to communicate and coordinate efforts to determine if a child had other insurance.

2. Because of the continuing interest in the MIChild program, the Department provides monthly updates to a variety of agencies.

5.1.7 Evaluation and Monitoring (including data reporting)

See Attached I for Client Satisfaction Survey. Encounter and HEDIS data are expected to be available Summer 2000.

5.1.8 Other (specify)

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

We will continue to promote our CHIP program through various outreach efforts and will continue to investigate other possible ways to increase the number of insured children in our state.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

1. The 10 percent limit on administrative expense is a structural barrier to an effective CHIP outreach program. This is especially problematic given that most states are having difficulty in finding and enrolling in the program a large percentage of the eligible children who are thought to be "out there." A solution would be legislation that distinguishes outreach activity from activities that administer the program. Such a distinction would allow for continued limits on administrative activity while freeing

funds for outreach. The program's single greatest challenge is to find and enroll the children eligible for the program.